

GRAMPAW PETTIBONE

Weather Challenges Judgment

A flight of 15 planes received contact clearance for a ferry flight over rough terrain. Weather conditions were poor (1,000 ft. ceiling), but instead of improving, as predicted, the weather deteriorated. The flight leader continued toward his destination, however, and did not turn back until weather conditions were far below contact.

Two planes crashed on the return flight.

► **COMMENT**—The flight leader was chiefly responsible for these crashes. He exercised extremely poor judgment in delaying his decision to return until forced to do so by bad weather. He should have complied with flight regulations and returned to his point of departure as soon as it became evident that the flight could not proceed under contact rules.

The delay in deciding to turn back was particularly bad in this case because of the special circumstances involved: a. the route was over rugged terrain, b. the flight consisted of a large number of planes, c. some of the pilots had very little experience in this type airplane and were rusty on instrument flying.

Not Good to the Last Drop

Upon returning to the field, an F4U pilot called the tower and asked permission to land immediately, stating that he was on reserve and that his gauge read 20 gallons. The tower acknowledged but told him to circle the field until a group of planes had taken off. After making one circuit, the pilot again requested permission to land, giving his fuel gauge reading. He was told to continue circling. A little later he called the tower and told them that his gauge read 10 gallons. The tower then gave him landing clearance and he immediately began his approach. He ran out of fuel before he reached the field, however, and was forced to land in a melon patch. The gas gauge still read 10 gallons. The airplane received major damage.



Grampaw Pettibone says:

The tower personnel were left holding the bag on this accident. Their casual attitude was not commendable.

Errors of other personnel are poor comfort to a crashed pilot, however. He must always look out for his own safety. This accident could have been prevented if the pilot had considered the situation more carefully. He should have known that with



such a low gas gauge reading, his engine might quit at any moment. Realizing this, he should have protected himself by getting more altitude and staying close enough to the field while circling to be able to glide in from any position.

How to Shoot Your Own Tail Off

In preparation for free gunnery practice, the radioman in an SB2C discovered that the barrel covers were still on the guns. He left the hatch open about six inches and started to release the guns from the secured position. As he did so, the port gun commenced firing. Fifty rounds went through the tail section before the surprised radioman could raise the cover plate and stop the cartridge feed.

The pilot reacted correctly in this emergency. Upon realizing that his rudder control was partially shot away, he climbed to 5,000 feet and thoroughly tested his control reaction before attempting to make a landing.

The Trouble Board said: "A live round of ammunition had to be in the chamber in order to have caused this accident. This was due to the negligent act of some person or persons unknown. However, the radioman was also negligent in that he did not check his guns before inserting his belt of ammunition."

"An investigation of the gun showed the bellcrank trigger extension to be raised about one-eighth of an inch owing to misalignment of roller and bell-

crank. This, coupled with the additional shock upon releasing the guns from the stowed position, raised the bellcrank sufficiently to cause the gun to fire."

It's Reserved for You

The cadet pilot of an SNJ-4 exhausted the fuel from his right main tank while on a night tactics flight and then shifted to the left main. The flight continued uneventfully until the student entered the traffic circle at his home field. His engine suddenly cut out at 500 feet. His prompt reaction was to shift the fuel selector valve to the right main tank. Naturally, the engine did not resume operation and a forced landing was necessitated. The cadet was injured and the airplane practically washed out.

Immediate inspection of the fuel system showed the right tank to be empty and the left tank empty except for approximately 18 gallons remaining in the reserve.



Grampaw Pettibone says:

This sort of thing is one of the most common causes of engine failures. When pilots learn their fuel systems and know how and when to shift tanks, I promise you the accident rate will take a significant turn for the better.

Floating Debris

Upon return from a fleet mission, a pilot made a normal landing approach with a J2F-5. After the plane had made a short run on the water, the port wing hit an unknown object and the plane water looped, turning over on its back. The pilot extricated himself but the radioman was trapped and drowned.

The Trouble Board found that the port wing tip float had been dented from its contact with the unidentified driftage. The investigators recommended that harbor craft assigned patrol duties in seaplane operating areas be alerted to the absolute necessity of clearing such areas of all floating debris.



Grampaw Pettibone says:

Alert your boat crews now—don't wait for an accident.

Tower operators and beach crews also can contribute to flying safety by promptly reporting any suspicious objects seen in operating areas. It is better to send a boat out to investigate a suspicious object that turns out to be harmless than to neglect to report driftage which will cause accident.

Advance Bases

LET NANES
HEAR FROM YOU!



Navy "Hellcat" is poised awaiting take-off signal from the Fly One officer who is intent on seeing that preceding plane clears the deck. Landing signal officer in background directs the approach of another plane. This is typical of the split second timing aboard a U. S. escort carrier



Corsair Fire Hazard

An explosion occurred in the fuselage of an F4U-1 when the mech started the engine. Flame entered the cockpit and caused so much damage before it could be brought under control that the airplane had to be scrapped.

BuAer has received reports of several similar fires in this airplane. They occur in those planes in which the Y duct is removed and the opening around the drop tank fitting in the bulkhead, at station 100, is unsealed. Units are cautioned that gasoline may drain back into the fuselage through this opening while fuel strainers are being drained.

BuAer Change 163 provided for sealing this opening in bulkhead 100. This change should be incorporated at the earliest opportunity.

Insidious Effects of Anoxia

Recently a pilot flew a PBM-3D airplane with no oxygen equipment installed or carried, to an indicated altitude of 20,000 feet. A total of approximately 50 minutes was spent at altitudes in excess of 15,000 feet, the greater part of it between 18,000 and 20,000. At the end of this period a series of violent maneuvers threw the crew members about the plane "like peas in a shoe box," the airplane breaking apart in the air at about 17,000 feet. An explosion in the center hull occurred nearly simultaneously.

The considered opinion of investigating authorities was that the violent maneuvers were caused by a stall and spin resulting in structural failure and internal explosion. Five of the fourteen crew members survived the crash via parachute, the remainder including pilot and two co-pilots perished.

As reported by the survivors, the apparent effects of anoxia were exhibited by everyone in the crew, although in widely varying degrees. The pilot was described as being exuberant and exhilarated, the second pilot as being perturbed, impatient and anxious. The flight engineer was hilarious, while other members of the crew suffered from severe headaches, dizziness and extreme drowsiness.

► **COMMENT** — This is a particularly flagrant case of violation of orders and instructions regarding the use of oxygen. All that part of the flight above 15,000 feet was an obvious violation of Technical Order 54-44. There are indications in this case that the pilot went further in tempting fate than he probably intended at the start of the flight above 15,000 feet. This may logically be attributed to the insidious effects of anoxia and is indicated by the fact that the pilot had ordered an "aban-

don ship" drill just before the accident. With a crew suffering from lack of oxygen, this bears little resemblance to clear thinking. Furthermore, at one point during the climb-up at about 18,000 feet, the pilot was observed to place his feet on the controls and move the elevators up and down. While this was not a violent maneuver, it was at least unusual for patrol plane operation.

This case is described at length in order to impress upon all naval pilots that existing orders and instructions regarding the use of oxygen must be soberly regarded and strictly obeyed.

ATR Revised

The Aircraft Trouble Report form and the instructions for submitting it have been revised in Aviation Circular Letter 48-44. All instructions are now contained in one letter. It is no longer necessary to maintain a sheaf of letters, pamphlets, and ALNAV's in order to submit a proper report.

The term "Aircraft Trouble Report" is a carry-over from the time when this report served its present purpose plus that of a RUDM and also a Striking Report, consequently the previous instructions transgressed somewhat into the field of these reports. Now that the report is confined to reporting aircraft accidents, the name is changed to *Aircraft Accident Report*, and all instructions pertaining to RUDM's, or striking are omitted to eliminate confusion.

Superficially, it would appear that additional reports have been introduced, since the report includes NavAer forms 339, 339A and 339B. Actually, NavAer forms 339A and B are rough worksheets to assist the board in obtaining the requisite information. Form 339A contains numerous items necessary for the proper analysis of the accident and space is provided to state in words how the items checked contributed to the accident. These remarks are then transcribed to the smooth form NavAer 339 which can be typewritten throughout. NavAer form 339B is a medical worksheet designed to bring to light the physiological aspects of the accident so that counter measures may be initiated to reduce the seriousness of personnel injuries incident to accidents.



Since this is the first issue of the *Aircraft Accident Report*, it is quite conceivable that imperfections may exist; therefore, comments, recommendations, and constructive criticism are invited.

BEST ANSWERS

China

Pick the best choice to complete the statements below, then check your answers on page 40.

1. In many parts of China, there is a superstition that if a photograph is taken it will—

- ☐ a—remove a person's soul
- ☐ b—make them bald
- ☐ c—cause loss of teeth
- ☐ d—cut their lives in half

2. The Chinese have an ancient belief that the hairier people are, the more—

- ☐ a—intelligent they are
- ☐ b—uncivilized they are
- ☐ c—quarrelsome they are
- ☐ d—money they have

3. When a Chinese host passes a bowl of tea to a guest, the guest should take it with—

- ☐ a—the left hand
- ☐ b—both hands
- ☐ c—the right hand
- ☐ d—the palm of the right hand

4. At a Chinese feast, it is always good manners to—

- ☐ a—eat all the food offered
- ☐ b—eat all the sweetmeats offered
- ☐ c—refrain from eating anything you don't want
- ☐ d—be informal

5. At a Chinese feast, the dessert is served—

- ☐ a—first
- ☐ b—last
- ☐ c—in the middle of the meal
- ☐ d—only when requested

6. The Chinese consider drunkenness a sign of—

- ☐ a—good-heartedness
- ☐ b—low breeding
- ☐ c—culture
- ☐ d—sociability

7. A Chinese shopkeeper will—

- ☐ a—respect you if you pay the first price he asks
- ☐ b—expect you to become angry when bargaining with him
- ☐ c—admire you if you pay one-half to two-thirds of what he asks
- ☐ d—prefer to sell at less than half the first price he asks